PostScript

LETTERS

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Vaginitis emphysematosa

Vaginitis emphysematosa is usually a self limited cystic disorder of the vagina. The paucity of reports on this rare entity and the fact that it can first present to the sexually transmitted diseases (STD) clinic where, for want of a better diagnosis, it may be passed off as condyloma acuminatum, prompted us to document the condition in a young woman.

Case report

A 29 year old gravida 8, para 8 woman presented with an asymptomatic growth in the vaginal introitus of 2 years' duration. It had started spontaneously, gradually attained the size of a small lemon, and had remained as such for months. On examination she was of average build and nutrition without any associated disorders like diabetes and hypertension. Local examination revealed a pedunculated mass measuring 2 cm in diameter protruding from the right side of the labia minora. There was no discharge and no other abnormality was visualised. The regional lymph nodes were not enlarged. Systemic examination revealed no abnormality. Routine blood tests, including VDRL and urinalysis were within normal limits. The lesion was excised with a provisional diagnosis of condyloma acuminatum and sent for histopathology. Light microscopic examination revealed a normal vaginal epithelium. The lamina propria contained multiple cysts of varying sizes (fig 1). The cysts were lined by a single layer of cuboidal cells. Most of the cysts were empty except for scanty hyaline material in some of the larger ones. In between the cysts were lymphohistiocytic infiltrates. Few scattered plasma cells were seen but there were no granulomas or giant cells.

Comment

Vaginitis emphysematosa is not only a rare condition but it is seldom diagnosed on examination as it lacks specific features to arouse clinical suspicion. Hence it has often been the histopathologist or the radiologist[1] who hints at the possibility of vaginitis emphysematosa. In an exhaustive review of the English literature[2] the salient features brought out include the occurrence of vaginitis emphysematosa in a wide age range after menarche to well beyond menopause, frequent association with pregnancy and at times cardiopulmonary disease, and involvement of the lamina propria of the upper vagina, extending at times to the lower vagina, the cervix, and rarely the vulva. The main interest in vaginitis emphysematosa has been the histopathological presence of empty cavities in the lesions containing gas similar to atmospheric air[3] with a high concentration of carbon dioxide.[4] How exactly these gases are produced is not clear. Some attribute this to associated trichomonal or *Gardnerella* infection, the cure of which resulted in apparent subsidence of vaginitis emphysematosa.[5] Immunosuppression as a predisposing factor leading to the development of vaginitis emphysematosa has also been suggested.[6]

Our patient presented with a lesion at the lower end of the vagina that was initially diagnosed as condylomata acuminata. She was not pregnant and had no associated vaginal infection, cardiac disease, or evidence of immunosuppression. Mild inflammatory signs were seen in our patient. Though the term "vaginitis" has been employed it has been observed that inflammation is generally mild or absent.[2] This may also account for the lack of symptoms in most of these patients. The natural course for vaginitis emphysematosa is to resolve spontaneously and in most patients this has been an accidental finding. On those occasions when the mass makes the patients seek advice simple excision may done as in the present case. Apart from solid tumours like condylomata acuminata, other benign cystic lesions of the vagina like inclusion cyst, Gartner duct cysts, and endometriosis should be considered in the differential diagnosis.

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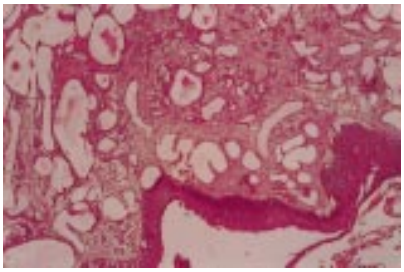

Figure 1 Photomicrograph showing multiple cysts (haematoxylin and eosin stain; original magnification ×40).

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Management of screened chlamydia positive women

Evidence based and minimally harmful management of screened positive people is an essential component of any screening programme.

In the pilot chlamydia programme the protocol for those who screened positive included testing for other genital tract infections.[1 2] This policy is not evidence based and requires evaluation before roll out of the screening programme nationally.

During the 12 month period September 1999 to August 2000 in Wirral and Portsmouth women throughout the communities up to the age of 25 years were offered a urine LCR test, in general practices, family planning clinics, gynaecology, antenatal, and termination of pregnancy services. Departments of genitourinary medicine (GUM) also offered the test though clearly these were usually for diagnosis rather than true screening.

Results were sent to everyone tested, as in other screening programmes, and an overall positivity of some 10% was found.

Both pilot sites had a central office, which was the initial point of contact for all testing positive. This avoids disparate management by different health professionals and services and had the added benefit of removing concerns raised about time required in each service for managing results, treating, counselling, and partner notification. As our previous experience showed that many people delayed or did not attend a department of GUM when referred,[3 4] two experienced health advisers were appointed on Wirral and based in the pilot office. These community health advisers had overall responsibility for ensuring and documenting that correct management occurred. People testing positive and reporting symptoms or risk factors were strongly advised to attend the department of GUM and were given a referral letter. However, those who were asymptomatic and who indicated that they did not wish to go were treated according to patient group directions with doxycycline, azithromycin, or erythromycin as appropriate. In these cases the health advisers undertook partner notification and sometimes their treatment. The pilot coordinator (JJH) undertook overall clinical responsibility and saw patients as needed.

During the 12 months of the pilot programme 112 women tested chlamydia positive by the "screening" test in GUM and most returned there for management. Sexually

Key messages

(1) Bacterial co-infection of chlamydia diagnosed during screening outside STI clinic settings is low
(2) Routine diagnostic testing should only be reserved for those symptomatic or with special risk
(3) Testing of the original urine sample for gonorrhoea is an acceptable alternative

transmitted infections in these women comprised three cases of gonorrhoea, 30 of genital warts, and six of herpes simplex. There were also 11 cases of candida and 18 of bacterial vaginosis. These figures represent multiple infections for several women.

Four hundred and six women screened in other healthcare settings tested chlamydia positive. The community health advisers treated 321 of these and 85 agreed to attend GUM. Five of these women (5.8%) had another sexually transmitted infection comprising only one case of gonorrhoea, two cases of genital warts, and two cases of genital herpes. There were also nine cases of candida and 17 of bacterial vaginosis.

If efficient and effective treatment for chlamydia is to take place in the community then health advisers will be essential as in the Wirral pilot scheme. They will need to establish in each case whether there are symptoms or special risk factors that transform the process from screening to one of diagnosis. Although diagnosis should involve testing for all relevant causes of the symptoms, we have found no evidence to support this as routine in a screening programme if it is known that the community prevalence of other significant infections is low. The invasive nature and possible stigmatisation by seeking for other infections together with the cost to individuals and the health service could be balanced against any personal or community benefits from the strategy.[5]

The women who chose to be treated in the community were offered a test for gonorrhoea (by LCR) on the original urine sample which had been frozen in the Liverpool Public Health Laboratory. Two of 192 women accepting this were found to have a positive test and were then referred to GUM clinics. This appears to be an acceptable and efficient means of finding this infection in those who would not otherwise present for testing.[6]

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NOTICES

International Herpes Alliance and International Herpes Management Forum

The International Herpes Alliance has introduced a website (www.herpesalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

Pan-American Health Organization, regional office of the World Health Organization

A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@tsp.sheridan.com).

7th Congress of the European Society of Contraception, "Changing attitudes to contraception and reproductive health"

10–13 April 2002, Genoa, Italy

Further details: ESC Central Office, OrgaMed, Essenestraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed@village.uunet.be).

MSSVD course in STIs and HIV: Module 1, Epidemiology of STIs and Bacterial Infections

22–25 April 2002, at the Institute for Materials, 1 Carlton House Terrace, London

Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV: Module 2, Sexual Health and Sexuality,

26 April 2002, at the Institute for Materials, 1 Carlton House Terrace, London

Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV: Module 3, Viral Infections other than HIV

20–21 May 2002, at the Institute for Materials, 1 Carlton House Terrace, London

Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV: Module 4, HIV Infections

22–24 May 2002, at the Institute for Materials, 1 Carlton House Terrace, London

Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

10th International Symposium on Human Chlamydial Infection

16–21 June 2002, in Antalya, Turkey

The scientific programme will encompass the breadth of chlamydial research from clinical and epidemiological studies to molecular and cell biology of all species of *Chlamydia*. Further details: Professor A Demir Serter, Department of Clinical Microbiology and Infectious Diseases, Ege University, Faculty of Medicine, 35100 Bornova, Izmir, Turkey (fax: 90 232 343 71 30; e-mail: ISHCIX@itsa.ucsf.edu).

10th International Congress on Behçet's Disease

27–29 June 2002, Berlin

Further details: Professor Ch Zouboulis (email: zoubbere@zedat.fu-berlin.de).

20th World Congress of Dermatology

1–5 July 2002, Paris

Further details: P Fournier, Colloquium, 12 rue de la Croix St Faubin, 75011 Paris, france (tel: +33 1 44 64 15 15; fax: +33 1 44 64 15 16; email: p.fournier@colloquium.fr; website: www.derm-wcd-2002.com).

18th Congress on Sexually Transmitted Infections IUSTI-Europe 2002

12–14 September 2002, Vienna, Hofburg Congress Center,

Chair of the Congress, Director of the European Branch of IUSTI: Angelika Stary, MD (Austria) Further details: Angelika Stary, c/o Administrative and Scientific Secretariat, Vienna Academy of Postgraduate Medical Education and Research, Alser Strasse 4, A-1090 Vienna, Austria (tel: (+43 1) 405 13 83 13; fax: (+43 1) 407 82 74; email: iusti 2002 @medacad.org; website: www.iusti-europe-2002.org).